

CERTIFICATE OF DEATH

Reg. Dist. No.

04558

04555

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meyersdale Pa.	
c. LENGTH OF STAY IN 1b 2 yrs.		75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Goodwill Mennonite Home, Inc.		d. STREET ADDRESS 236 Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle C. Last Boachy		4. DATE OF DEATH Month April Day 30 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-80
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) USA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Waddy Currin		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
INFORMANT H. Johnson Address Berlin, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic brain syndrome 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebroarteriosclerosis DUE TO (c) 4 years			INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1 , 19 61 , to April 30 , 19 62 , that I last saw the deceased alive on 4-29 , 19 62 , and that death occurred at 6:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Grantsville, Md. DATE SIGNED April 30, 1962			
ACTUAL SIGNATURE G. Paige Strong		M.D. Grantsville, Md.	
PHYSICIAN'S NAME (Type) A. Paige Strong, M.D.		Grantsville, Md.	
22a. BURIAL, CREMATION, or other disposal (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5-3-62	MT. LEBANON	RD 1 GLENCOE, Pa
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman, Grantsville Md.		24a. REC'D BY REGISTRAR DATE MAY 4 '62	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled out by the attending physician or the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04559 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04556

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, c. LENGTH OF STAY IN b 35 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cr. Third & Crook Sts.				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XOakland, d. STREET ADDRESS Cr. Third & Crook Sts. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth May Beckman				4. DATE OF DEATH Month Day Year April 15th 19 62											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1888		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY Tourist Home				11. BIRTHPLACE (State or foreign country) Garrett County, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Daniel E. Beckman						14. MOTHER'S MAIDEN NAME Sarah Lohr									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address Ray Beckman R.D. Swanton, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oak., Md. 4-15-62															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/1962		22c. NAME OF CEMETERY OR CREMATORY Fitzwater Cemetery, North Glade, Swanton, Md.				22d. LOCATION (City, town, or country) (State)							
23. FUNERAL DIRECTOR <i>H. C. Lighton</i> ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE APR 19 '62		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>									

FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04550 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04557

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Pa. b. COUNTY Somerset			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Sang Rund, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Somerset			
c. LENGTH OF STAY IN 1b Hours				d. STREET ADDRESS 806 Smith Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Irvin Middle S Last Berkebile, Jr.				4. DATE OF DEATH Month April Day 25th Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-18-1930	
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman				10b. KIND OF BUSINESS OR INDUSTRY Pa. Electric Co. Somerset Co., Pa.			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Irvin S. Berkebile Sr.				14. MOTHER'S MAIDEN NAME Hazel Kennel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 174-24-3860			
17. INFORMANT Mrs. Irvin Berkebile Jr				Address 806 Smith St Somerset Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution (110,000 volts) 914.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) While blasting, blasting cable came into contact with 110,000 volt line INTERVAL BETWEEN ONSET AND DEATH Sudden							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While blasting, blasting cable came into contact with 110,000 volt line			
20c. TIME OF INJURY Hour 2:30 p.m. Month, Day, Year 4-25-62 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Along power line		20f. (City or town) (County) (State) Rural, Sang Run Garr. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James H. Feaster, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/29/1962			
22c. NAME OF CEMETERY OR CREMATORY Somerset Co. Mem. Park				22d. LOCATION (City, town, or country) (State) Somerset Pa			
23. FUNERAL DIRECTOR Gerald M. Munnich				24a. REC'D BY REGISTRAR MAY 2 '62			
ADDRESS Oakland, Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed and filed in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

04561

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04558

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK c. LENGTH OF STAY IN 1b 18 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DEER PARK		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK d. STREET ADDRESS DEER PARK e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle FULSON Last BROWN		4. DATE OF DEATH Month APRIL Day 11 Year 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 3, 1887 9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WOODSMAN		10b. KIND OF BUSINESS OR INDUSTRY TIMBER CUTTER	
11. BIRTHPLACE (County & State, or foreign country) CLEARFIELD, PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER BROWN		14. MOTHER'S MAIDEN NAME CATHERINE BECKWITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-10-3108	
17. INFORMANT COLUMBIA F. BROWN DEER PARK, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Arteriosclerosis grandaect. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis grandaect. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 Apr 1962 to 11 Apr 1962 that (I) (we) last saw the deceased alive on 10 Apr 1962 and that death occurred at 3:00 from the causes and on the date stated above.			
22a. SIGNATURE B.L. Grant		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) B.L. GRANT, M.D.		22d. ADDRESS OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/13/1962	
23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		23d. LOCATION (City, town or county) (State) GARRETT COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE H.C. Loughton		25a. REC'D BY REGISTRAR APR 18 '62	
ADDRESS OAKLAND, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04562

04359

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W. Va. b. COUNTY Grant ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayard	
c. LENGTH OF STAY IN 1b 11 Days		d. STREET ADDRESS General Delivery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harold Vincent Casey		4. DATE OF DEATH April 1 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1901
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Forman	
11. BIRTHPLACE (County & State, or foreign country) Barton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Casey		14. MOTHER'S MAIDEN NAME Martha McIntyre	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unk.	
17. INFORMANT (Wife) Edith Casey, Bayard, W. Va.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Auricular fibrillation DUE TO Chronic myocarditis		INTERVAL BETWEEN ONSET AND DEATH 10 days 6 mos. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Two previous myocardial infarctions		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from 1949 to 4-1-62 , 19....., that (I) xxx last saw the deceased alive on 4-1-62 19....., and that death occurred on 4-1-62 11:10 P. M. from the causes and on the date stated above.			
22a. SIGNATURE James H. Feaster, Jr., M.D.		22b. DATE SIGNED 4-2-62	
22c. PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M.D.		22d. ADDRESS 58 2nd. S., Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/4/62	
23c. NAME OF CEMETERY OR CREMATORY Bayard Cemetery		23d. LOCATION (City, town or county) (State) Grant W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald D. Minnich		25a. REC'D BY REGISTRAR APR 9 '62	
ADDRESS Oakland, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04563 MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04560

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland,</u> c. LENGTH OF STAY IN <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route #219, 7 Mi. S. Oakland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u> d. STREET ADDRESS <u>Rosedale</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Lawrence Childs</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11th</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 4, 1904</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. F UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman, Sterling Processing Co.</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Garrett County, Md.</u>	
11c. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James F. Childs</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Leech</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>336-50-0010</u>	
17. INFORMANT <u>Mrs. Sylvia Childs</u>		Address <u>Oakland, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u> DUE TO (b) <u>Ruptured heart</u> DUE TO (c) <u>Broken Neck</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> " "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car crossed road and struck another auto. Rt. 219</u>		20c. TIME OF INJURY Month, Day, Year <u>2:15</u> <u>4-11-62</u> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>Rural, Oak. Garr.</u> (County) <u>Md.</u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or country) <u>Oak., Md.</u> (State) <u> </u>	
23. FUNERAL DIRECTOR <u>W. H. Leighton</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	
ADDRESS <u>Oakland, Md.</u>		DATE <u>APR 18 '62</u>	



YR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04565 CERTIFICATE OF DEATH 04562

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN b <u>6 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Garrett County Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Accident</u> d. STREET ADDRESS <u>X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jefferson</u> (None) <u>Deal</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1881</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>81</u> Days <u>24</u> Hours <u>19</u> Min. <u>62</u>		4. DATE OF DEATH <u>April 24 1962</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> 11. BIRTHPLACE <u>Garrett County, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Deal, Samuel</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Burkholder, Elizabeth</u> 16. SOCIAL SECURITY NO. <u>Mabel Haenftling, Accident, Md.</u> 17. INFORMANT <u>Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cholesterol Rt. Leg.</u> DUE TO <u>Advanced Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1959</u> to <u>Apr 24, 1962</u> that (I) (we) last saw the deceased alive on <u>Apr 23, 1962</u> and that death occurred at <u>1:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. E. I. Baumgartner</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. E. I. Baumgartner</u>		22b. DATE SIGNED <u>4/24/62</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Oakland, Maryland</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial 4/26/62</u> REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORY <u>St Paul's</u> 23d. LOCATION (City, town or county) (State) <u>Accident, Garrett Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jon Newman, Grantville, Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>APR 27 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Wm. L. Finner</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason in the space provided. To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason in the space provided. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04566 Item 9 Film 0311 4/16/62 mh

1. PLACE OF DEATH
a. COUNTY **Garrett** b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Oakland** c. LENGTH OF STAY IN 1b **22 months** d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Cuppett-Weeks Nuring Home**

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE **Maryland** b. COUNTY **Allegany** c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Cumberland Md** d. STREET ADDRESS **1 Strandview Terrace** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **Warren** Middle **DeHaven** Last **DeHaven** 4. DATE OF DEATH Month **April** Day **6th** Year **19 62**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **6/11/99** 9. AGE (In years last birthday) **62 yrs** IF UNDER 1 YEAR Months **6** Days **11** IF UNDER 24 HRS. Hours **11** Min. **00**

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) **Retired** 10b. KIND OF BUSINESS OR INDUSTRY **Bartender** 11. BIRTHPLACE (State or foreign country) **Cumberland Md** 12. CITIZEN OF WHAT COUNTRY? **U.S.A**

13. FATHER'S NAME **Charles DeHaven** 14. MOTHER'S MAIDEN NAME **Lily Davis**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Nursing Home, Oakland Md** Address **Oakland Md**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Cardiac decompensation, acute**
DUE TO **Arteriosclerotic heart disease**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. **years**
DUE TO **years**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **4-6-62**

ACTUAL SIGNATURE **James H. Feaster, Jr.** EXAMINER'S NAME (Type) **James H. Feaster, Jr., M. D.** Address (Street, city, town, or county) **Oak., Md.**

22a. BURIAL, CREMATION OR REMOVAL (Specify) **Burial** 22b. DATE THEREOF **4/11/62** 22c. NAME OF CEMETERY OR CREMATORY **County Cem.** 22d. LOCATION (City, town, or country) (State) **Cumberland Md**

23. FUNERAL DIRECTOR **Louis Stein Inc.** ADDRESS **Cumb. Md** 24a. REC'D BY REGISTRAR **APR 12 '62** 24b. REGISTRAR'S SIGNATURE **Arthur L. Kraus**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. If you please remove carbon pages 1 and 2 from the certificate and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04567

04564

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN b. 20 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE d. STREET ADDRESS P.O. BOX 62 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JASPER THOMAS FIKE		4. DATE OF DEATH APRIL 29, 1962	
5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH AUG. 1, 1873 9. AGE (In years (If UNDER 1 YEAR, last birthday) Months Days Hours Min.) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman 11. KIND OF BUSINESS OR INDUSTRY Southern Pipe Line Accident 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FIKE Jack 14. MOTHER'S MAIDEN NAME Fraunce Frayer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. 196-10-7671 17. INFORMANT Mr. Clyde Sauner Friendsville Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) UREMIA DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Generalized ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 10 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1958 to 4/29/1962 that (I) (we) last saw the deceased alive on 4-28-1962, and that death occurred at 8:52 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Pedro Rivera 22c. PHYSICIAN'S NAME (Type) PEDRO RIVERA, M.D.		22b. DATE SIGNED 4-30-62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS FRIENDSVILLE, MARYLAND	
23a. BURIAL, CREMATION, or other disposition 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) Burial May 2, 1962 Addison Cemetery Addison Pa		24. FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Don Newman, Grantsville, Md DATE MAY 7 '62 Clifford L. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
04568 CERTIFICATE OF DEATH 04565									
Items 8 & 9 line 0912 3/10/62 iwk									
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission on) a. STATE Maryland b. COUNTY Garrett							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mill Run					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppert-Weeks Nursing Home				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Walter First Middle Last		4. DATE OF DEATH April 29 Month Day Year		1962					
5 SEX M	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 7 1872	9. AGE (In years lost birthday) 90 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tellbipport, Md			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13 FATHER'S NAME Heriam Frazee				14 MOTHER'S MAIDEN NAME Rebecca Poland					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Dorothy Clark, Hamedville, Pa Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized xxxx arteriosclerosis DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 hrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from March 28, 1962 to April 29, 1962 that (I) (we) last saw the deceased alive on April 29, 1962 and that death occurred on April 29, 1962 at 12:20 PM and the cause and on the date stated above.									
22a. SIGNATURE B. L. Grant, M.D.		M D		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 5/1/62			
22c PHYSICIAN'S NAME (Type) B. L. Grant, M.D.		22d ADDRESS Oakland, Md.							
23a BURIAL, CREMATION, OR REMOVAL (Specify)		23b DATE THEREOF May 2, 1962		23c NAME OF CEMETERY OR CREMATORY Addison Cemetery		23d LOCATION (City, town, or county) (State) Addison, Pennsylvania			
24 FUNERAL DIRECTOR'S SIGNATURE Don Harman - Huntville, Md.				ADDRESS		24a REC'D BY REGISTRAR MAY 7 '62		25b REGISTRAR'S SIGNATURE Arthur E. Kunes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04569

CERTIFICATE OF DEATH

04566

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY (If not in hospital, give street address) 23 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRELLIN d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MABEL First Middle Last FRIEND		4. DATE OF DEATH APRIL 11 1962 Month Day Year	
5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 3, 1899 9. AGE (In years, if under 1 year; last birthday) Months Days Hours Min. 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE County & State or foreign country. GARRETT COUNTY, MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DUEL, LYMAN		14. MOTHER'S MAIDEN NAME BUTLER, AIREY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HUSBAND-FRIEND GEORGE MARCELLUS		Interval between onset and death 2 wks	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 100% DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Chronic pyelonephritis and large aneurysmal type aortic aneurysm DUE TO 4-6 yrs 4-6 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from, APRIL 11, 1962, to APRIL 11, 1962, that (I) (we) last saw the deceased alive on APRIL 11, 1962, and that death occurred at 4:35 P.M. causes and on the date stated above		22a. SIGNATURE A.E. Mance 22c. PHYSICIAN'S NAME (Type) A.E. MANCE MD. 22d. ADDRESS OAKLAND, MARYLAND 22b. DATE SIGNED 12/9/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/14/62 23c. NAME OF CEMETERY OR CREMATORY Ashby Cemetery 23d. LOCATION (City, town or county) (State) Garrett Maryland		25a. REC'D BY REGISTRAR APR 17 62 25b. REGISTRAR'S SIGNATURE Charles E. Hume	
24. FUNERAL DIRECTOR'S SIGNATURE Edward J. Munnich ADDRESS Oakland, Maryland			

04570

CERTIFICATE OF DEATH

Reg. Dist. No.

04567

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Pennsylvania b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mennonite Nursing Home		d. STREET ADDRESS East Main Street	
3. NAME OF DECEASED (Type or print) First LOTTIE Middle M. Last HAY		4. DATE OF DEATH Month April Day 20 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1893
9. AGE (In years last birthday) yrs 69		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Mankamyer		14. MOTHER'S MAIDEN NAME Nora Bittner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 280-28-0382B	
17. ADDRESS Robert W. Hay		18. ADDRESS Berlin, Penna.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic brain syndrome 4 6 7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Circulatory disturbance DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2, 1962 to April 20, 1962 that I last saw the deceased alive on April 19, 1962 and that death occurred at 6:57 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE A. Paige Strong		DATE SIGNED 4/20/62	
PHYSICIAN'S NAME (Type) A. Paige Strong, M.D.		ADDRESS (Street, city or town, state) Grantsville, Md.	
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 4/24/62	22c. NAME OF CEMETERY OR CREMATORY Berlin IOOF Cemetery	
22d. LOCATION (City, town, or county) (State) Berlin Somerset Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE Don Hummer - Grantsville, Md		24. REC'D BY REGISTRAR DATE APR 24 '62	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9,60

04571

STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04568

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before death, if different) e. STATE WEST VA. b. COUNTY PRESTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HORSE SHOE RUN		
c. LENGTH OF STAY IN 1b 10 days			d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL					
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle E Last HENLINE			4. DATE OF DEATH Month APR. Day 4, Year 19 62		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAR. 29, 1899	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) W.VA.	
13. FATHER'S NAME JOHN HENLINE			14. MOTHER'S MAIDEN NAME AGNES MAY MILLER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 232-09-9232		
17. INFORMANT (Name and address) (WIFE) Sarah Henline AGNES XXXX HENLINE			18. CITIZEN OF WHAT COUNTRY? U.S.A.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis with thrombosis DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Previous myocardial infarction INTERVAL BETWEEN ONSET AND DEATH Sudden					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-4-62 Address (Street, city, town or county) Oak., Md.					
ACTUAL SIGNATURE James H. Feaster, Jr. EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M.D.			22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
22b. DATE THEREOF 4/7/1962		22c. NAME OF CEMETERY OR CREMATORY XXXX Texas		22d. LOCATION (City, town, or country) (State) Horse Shoe Run, W.Va.	
23. FUNERAL DIRECTOR Wayne C. Spiggle			24a. REC'D BY REGISTRAR Davis, W.Va.		
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			DATE APR 9 '62		

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department for instructions. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9 60

04573

MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PLESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04570

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland Rt. 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett Co. Mem. Hospital, Oak., Md.		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Dessie Elizabeth Junkins		4. DATE OF DEATH April 11th 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/10/1889	
9. AGE (In years last birthday) 72 yrs.		10. AGE (In years last birthday) 72 yrs.	
11. BIRTHPLACE (State or foreign country) Bittinger, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lohr		14. MOTHER'S MAIDEN NAME Ellen Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. unk.	
17. INFORMANT Okareda Shaffer		Address Oakland Rt. 1, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Oak., Md. 4-11-62			
ACTUAL SIGNATURE James H. Feaster, Jr., M.D. EXAMINER'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/14/62 22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery 22d. LOCATION (City, town, or country) (State) Oakland, Maryland			
23. FUNERAL DIRECTOR Gerald N. Minnich ADDRESS Oakland, Maryland 24a. REC'D BY REG. STRAR APR 17 '62 24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

MEDICAL CERTIFICATION

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the director, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 9 60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b <u>7 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA Garrett Co. Mem. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> d. STREET ADDRESS <u>General Del.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mike</u> Middle <u>Sakalik</u> Last <u>Sakalik</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23rd.</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 16, 1916</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Summer Camp</u>	
11. BIRTHPLACE (State or foreign country) <u>Webster, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Sakalik</u>		14. MOTHER'S MAIDEN NAME <u>Susie (unk.)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give year or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>191-09-1537</u>	
17. INFORMANT <u>Mary Bright</u>		Address <u>Oakland, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY - IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary artery sclerosis</u> (c), stating the underlying cause last, (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> Years <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <u> </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) <u>Cen. Arlington, Virginia</u> (State) <u> </u>	
23. FUNERAL DIRECTOR <u>Herold N. Minnich</u>		24a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
ADDRESS <u>Oakland, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

04575

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Vindex</u>		LENGTH OF STAY (In this place) <u>7 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Vindex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>East Vindex</u>				STREET ADDRESS (If rural give location) <u>East Vindex</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Almedia - Sharpless</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 1, 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>June 19, 1890</u>	
				9. AGE last birthday <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Rosetta Harvey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-07-1986-B-</u>		17. INFORMANT & ADDRESS <u>Mrs. Esta Brown, Vindex, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
43-1 IMMEDIATE CAUSE (A) <u>Cardiac decompensation, acute</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Auricular fibrillation</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Arteriosclerotic cardiovascular disease.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1958</u> , 19....., to <u>3-23-62</u> , 19....., that I last saw the deceased alive on <u>3-23-62</u> , 19....., and that death occurred at <u>9 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James H. Feaster, Jr.</u>				ADDRESS (Street, city, town, state) <u>58 2nd. St., Oakland, Md.</u>		DATE SIGNED <u>4-3-62</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Apr. 4, 1962</u>		NAME OF CEMETERY OR CREMATORY <u>Sharpless Cemetery</u>		LOCATION (City, town, or county) (State) <u>Wt. Zion, Garrett Co. Md</u>	
24. REC'D BY REGISTRAR DATE <u>APR 5 '62</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Amey M. Sharpless</u>		ADDRESS <u>Laine, Va</u>	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

04576

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04573

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Swanton c. LENGTH OF STAY in 1b 40Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R#1-Mt.Zion Road			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Swanton d. STREET ADDRESS R#1, Mt.Zion Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clarence Everett Sharpless			4. DATE OF DEATH Month April Day 14th Year 1962		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH 7-13-21		
9. AGE (In years last birthday) 40 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner			10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		
11. BIRTHPLACE (State or foreign country) Vindex, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jess Francis Sharpless			14. MOTHER'S MAIDEN NAME Addie Mae Paugh		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-18-2046		
17. INFORMANT Address Mrs. Addie Sharpless, R#1, Swanton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of left chest, self inflicted DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Immediate		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted shotgun wound of left chest		
20c. TIME OF INJURY Month, Day, Year 5:30 a.m. 4-14-62			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James H. Feaster, Jr.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. CREMATION <input type="checkbox"/> REMOVAL (Specify) Burial			22b. DATE THEREOF April 17/62		
22c. NAME OF CEMETERY OR CREMATORY Turner Cemetery			22d. LOCATION (City, town, or county) (State) Oak., Md. 4-14-62		
23. FUNERAL DIRECTOR Amy M. Sharpless,			ADDRESS Blaine, W.Va.		
24a. REC'D BY REGISTRAR APR 19 1962			24b. REGISTRAR'S SIGNATURE C. J. H. H.		

1 FHR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04574

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hutton c. LENGTH OF STAY IN 1b 32 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hutton d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clayton Middle Joseph Last Slabaugh				4. DATE OF DEATH Month April Day 13th Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1889 9. AGE (In years last birthday) 72 If UNDER 1 YEAR: Months 72 Days 0 Hours 0 Min. 0 If UNDER 24 HRS.:	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Soft Coal Mines		11. BIRTHPLACE (State or foreign country) Garrett County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Slabaugh				14. MOTHER'S MAIDEN NAME Christina Durst			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-01-6124		17. INFORMANT Mrs. Clayton Slabaugh, Hutton, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of oesophagus with 151X DUE TO (b) metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c):						INTERVAL BETWEEN ONSET AND DEATH Months	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. Month 19 Day 19 Year 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.)		20f. City or town (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James H. Feaster, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/1962		22c. NAME OF CEMETERY OR CREMATORY Garrett Co. Mem. Gardens, Oakland, Maryland.		22d. LOCATION (City, town, or country) (State) Oak., Md. 4-14-62	
23. FUNERAL DIRECTOR A. E. Keightley				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR APR 18 '62	
				24b. REGISTRAR'S SIGNATURE Christina L. Hutton		24c. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. If the funeral director, page 3 should be detached for use as the burial-transit permit. If necessary, remove carbon page 3 and file with the State Dept. of Health.

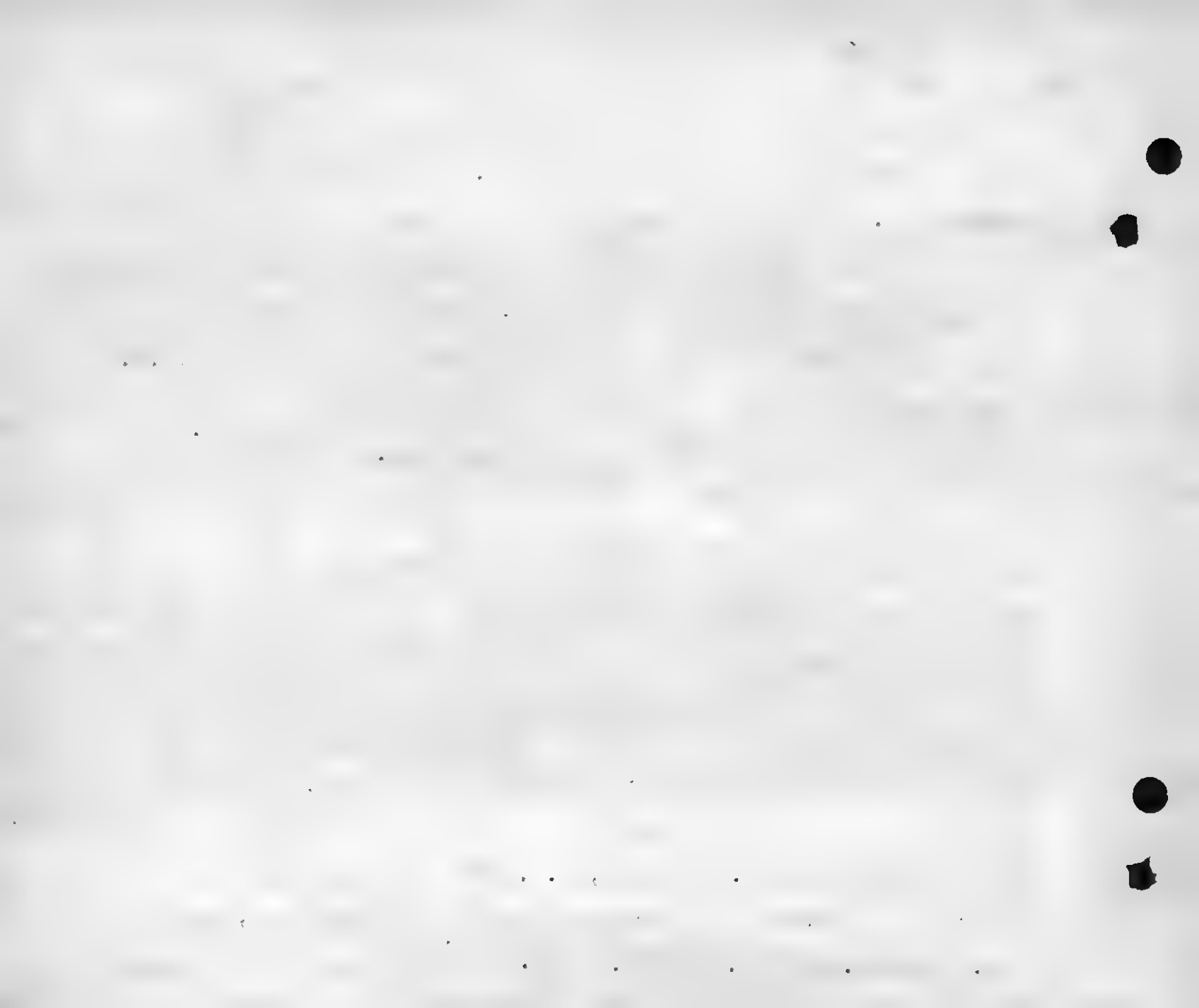
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04575

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b <u>2 1/2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Garrett Co. Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park</u> d. STREET ADDRESS <u></u>	
3. NAME OF DECEASED (Type or print) <u>Garrett Co. Memorial Hospital</u> First Middle Last <u>Sarah JANE Suggs</u>		4. DATE OF DEATH Month Day Year <u>April 28 1962</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-28-04</u> 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min. <u>58</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> 11. PLACE OF BIRTH (County & State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>John Riner</u> 14. MOTHER'S MAIDEN NAME <u>Julia Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>"Husband" Rev. William Suggs</u> Address <u>Mt. Lake Park, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Consecutive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Rheumatic Endocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) <u></u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING () OR CONTRIBUTING () CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>December</u> 20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from... <u>October 2, 1962</u> to <u>April 28, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 27 1962</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Herbert H. Leighton</u> 22c. PHYSICIAN'S NAME (Type) <u>Herbert H. Leighton, M.D.</u> 22d. ADDRESS <u>Oakland, Maryland</u>		22b. DATE SIGNED <u>28 Apr 62</u> 22e. REC'D BY REGISTRAR <u></u> 22f. REGISTRAR'S SIGNATURE <u>Wm. Cook Inc.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5/1/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Garden Of Faith</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Inc. 1217 St. Paul St. Md.</u> 25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>Wm. Cook Inc.</u>	



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
C4580
CERTIFICATE OF DEATH
04577

1. PLACE OF DEATH
a. COUNTY Garrett
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett County Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE (W. Va.) Md.
b. COUNTY (Lives in Md.) Garrett
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route # 1 Thomas
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) Anna May Turek
4. DATE OF DEATH April 3 1962
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH March 3, 1915
8. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR Months Days Hours M. n.
9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR Months Days Hours M. n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (Country & State or foreign country) Henry, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Kuski, Pete
14. MOTHER'S MAIDEN NAME Kuski, Anna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address James Turek, KEMPION, W. VA.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
4 + 4 + X DUE TO Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
INTERVAL BETWEEN ONSET AND DEATH 4 weeks
4 years

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959 to 1962, that (I) (we) last saw the deceased alive on 4-2-62, and that death occurred at 5:10 A.M. from the causes and on the date stated above.
22a. SIGNATURE James H. Feaster Jr. M.D.
22b. DATE SIGNED 4-3-62
22c. PHYSICIAN'S NAME (Type) Dr. James H. Feaster Jr.
22d. ADDRESS Oakland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF APR. 6, 1962
23c. NAME OF CEMETERY OR CREMATORY CATHOLIC
23d. LOCATION (City, town or county) (State) THOMAS, W. VA.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
25a. REC'D BY REGISTRAR DATE APR 6 '62
25b. REGISTRAR'S SIGNATURE



7



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



AP 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Form 321 4/15/62 7h

04581

CERTIFICATE OF DEATH

Reg. Dist. No. 04578

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kitzmillers</u>		c. LENGTH OF STAY IN TB <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kitzmillers</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Church</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>A</u> Last <u>Warren</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1883</u>	9. AGE (In years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR: Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min <u>4</u>		IF UNDER 24 HRS: Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Warren</u>				14. MOTHER'S MAIDEN NAME <u>? Shimnel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>232-14-1184</u>		17. INFORMANT <u>Charles A. Warren</u> Address <u>Oakland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Cerebral Hemorrhage with right-sided paralysis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 week</u> <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1961</u> to <u>April 4, 1962</u> , that I last saw the deceased alive on <u>April 4, 1962</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph Calandrella</u> M.D.				ADDRESS (Street, city or town, state) <u>Kitzmillers, Md.</u> DATE SIGNED <u>April 6-62</u>			
PHYSICIAN'S NAME (Type) <u>RALPH CALANDRELLA</u>				M.D. <u>Kitzmillers MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-8-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Kyle Pritts Jr.</u>				ADDRESS <u>Kitzmillers Md</u>		24. REC'D BY REGISTRAR DATE <u>APR 10 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Kitzmillers</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

04582
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04579
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton c. LENGTH OF STAY IN b. 78 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES HARMON WILT First Middle Last				4. DATE OF DEATH 4 15 1962 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 28, 84	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY General Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Stephen Wilt				14. MOTHER'S MAIDEN NAME Rhoda Broadwater			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. James H. Wilt-Swanton, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Cardiovascular Dis. YEARS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH Sudden YEARS							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-15-62 Address (Street, city, town, or county) ORAN TMD							
ACTUAL SIGNATURE James H. Feaster Jr.		EXAMINER'S NAME (Type) James H. Feaster, Jr.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/62	
22c. NAME OF CEMETERY OR CREMATORY Murphy Cem.		22d. LOCATION (City, town, or country) (State) Rural Swanton Md.		24a. REC'D BY REGISTRAR APR 18 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	
23. FUNERAL DIRECTOR Ed. Boal ADDRESS Westernport, Md.							

MEDICAL CERTIFICATION

10/12/41

STATE OF TEXAS
COUNTY OF DALLAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

SP. 37

DATE: 10/12/41
TIME: 10:00 A.M.

NAME: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

DEATH CERTIFICATE NO. [illegible]

REGISTRATION NO. [illegible]

FILE NO. [illegible]

DATE OF EXAMINATION: [illegible]

EXAMINER'S SIGNATURE: [illegible]

DEATH CERTIFICATE NO. [illegible]

REGISTRATION NO. [illegible]

FILE NO. [illegible]

DATE OF EXAMINATION: [illegible]

EXAMINER'S SIGNATURE: [illegible]

04583

CERTIFICATE OF DEATH

Reg. Dist. No.

04580

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Md.		c. LENGTH OF STAY IN TB 5 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Co. Md.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DORA Middle HOSTETLER Last YODER		4. DATE OF DEATH Month April Day 28 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1861
9. AGE (In years last birthday) 100		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Summitt Mills, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Hostetler		14. MOTHER'S MAIDEN NAME Nellie Willtrent	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Oma Yoder, Grantsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Acute Brain Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 18, 1962 to April 28, 1962 that I last saw the deceased alive on April 28, 1962 and that death occurred at 7 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. O. GLASSMAN		DATE SIGNED 4/30/62	
PHYSICIAN'S NAME (Type) C. O. GLASSMAN		ADDRESS (Street, city or town, state) 345 Main St Meyersdale Pa	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 5/1/62		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Horshberger		22d. LOCATION (City, town, or county) (State) Summit Mills, Somerset Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman		ADDRESS Grantsville, Md.	
24a. REC'D BY REGISTRAR MAY 3 1962		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

